1313-001 $ _____
1313-006 $ 10

TENNESSEE BOARD OF DISPENSING OPTICIANS
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
LOCAL (615) 532-5157
TOLL FREE (800) 778-4123

APPLICATION FOR LICENSE AS A DISPENSING OPTICIAN

INSTRUCTIONS

1. **Complete this application, have it notarized, enclose a non-refundable check for Two Hundred Thirty Dollars ($230) payable to the Board of Dispensing Opticians, and mail to the above address.**
2. **Provide proof of graduation from high school or general equivalency diploma (G.E.D.)**
3. **Attach a "passport" size photograph taken within the preceding twelve (12) months to the front of the application.**
4. **Attach a notarized photocopy of your birth certificate.**
5. **Attach proof of your current A.B.O./N.C.L.E. certification to the application.**
6. **Attach at least two (2) letters of recommendation to the application. At least one (1) letter must be from a current or former employer.**
7. **If you have ever been licensed in another state, complete page 5. Please provide a copy of your current license, proof of completion of an apprenticeship program, if applicable, and a copy of the licensing state's rules and regulations pertaining to licensing and to the examinations.**

CATEGORY OF APPLICATION: SELECT ONE

_____ 1. Graduate of a two (2) year Opticianry school. (Have a transcript sent directly from your school to us.)
_____ 2. Completed the three (3) year Tennessee Apprenticeship program.
_____ 3. Completed three (3) years apprenticeship training from another licensing state; or, licensed in a licensing state whose qualifications for licensure are equivalent or greater than Tennessee's.

NAME _____
First Middle and/or Maiden Last

DATE OF BIRTH _____ SOCIAL SECURITY# _____

CURRENT HOME MAILING ADDRESS: CURRENT PRACTICE ADDRESS:

_____ _____
_____ _____
_____ _____

HOME PHONE _____ WORK PHONE _____

List all states where you currently have, or have ever had, a Dispensing Optician License

_____ _____ _____ _____

CERTIFICATION OF EXPERIENCE IN OPHTHALMIC DISPENSING

Complete this form for every location you have worked in Ophthalmic dispensing. Make as many copies of this page as is necessary.

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

CITY **STATE** **ZIP**

TELEPHONE NUMBER **NAME OF DIRECT SUPERVISOR**

Employed in Position from _____, _____ to _____, _____.

TYPE OF ESTABLISHMENT OR OFFICE

_____ Ophthalmic Dispenser
_____ Contact Lens Manufacturer
_____ Contact Lens Technician
_____ Ophthalmologist's Office
_____ Other (specify) _____
_____ Wholesale Distributor
_____ Optometrist's Office
_____ Optician

CHECK THE SPECIFIC DUTIES PERFORMED IN THE ABOVE POSITION AND GIVE APPROXIMATE PERCENTAGE OF TIME ENGAGED IN EACH DURING A NORMAL WORK WEEK. TOTAL PERCENTAGE SHOULD ACCOUNT FOR 100% OF HOURS WORKED.

%	DUTIES PERFORMED
	Fitting and adjusting lenses to human faces
	Fitting contact lenses
	Interpreting prescriptions and making optical calculations
	Verifying
	Optical laboratory work (mechanical)
	Selling merchandise (other than ophthalmic materials)
	Stock work
	Office work
	Describe other duties not listed (managerial, etc.)

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application. For the purpose of these questions, the following phrases or words have the following meanings:

1. ***"Ability to practice as a Dispensing Optician"*** is to be construed to include all of the following:

    a. The cognitive capacity to make and exercise reasoned judgment and to learn and keep abreast of development in the field;
    b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
    c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. ***"Medical Condition"*** includes physiological, mental or psychological disorders, such as, but not limited to: orthopedic, visual, speech and/or hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

3. ***"Chemical Substances"*** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. ***"Currently"*** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. "***Illegal Use of Controlled Substances"*** means the use of controlled substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	YES	NO
Do you currently have a medical condition which in any way impairs or limits your ability to practice as a Dispensing Optician with reasonable skill and safety?	___	___
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	___	___
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner, in which you have chosen to practice?	___	___
(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether conditions should be imposed, or whether you are not eligible for licensure.)	___	___
Do you currently use chemical substances?	___	___
If yes, do they in any way limit your ability to practice optometry with reasonable skill and safety?	___	___
Are you currently engaged in the illegal use of controlled substances?	___	___
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in illegal use of controlled substances?	___	___
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	___	___
If you have ever held or applied for a license or certificate to practice as a Dispensing Optician in any state, county, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	___	___
Have you ever been rejected or censured by a Professional Association?	___	___
In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you?	___	___
b. Have you ever had settlement of any legal action rendered <u>against</u> you?	___	___
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	___	___
If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___

AFFIDAVIT OF APPLICANT

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying statements and transcripts are true, complete, and correct. I understand that any false or misleading information in or in connection with my application may be cause for denial or loss of certification. I further swear that I have read and understand the statutes and the Rules and Regulations, which were enclosed in the application packet, and agree to abide by them while licensed by Tennessee.

_____
Signature of Applicant

Sworn to and subscribed before me this _____ day of _____, _____.

My Commission Expires: _____ _____
(Notary Seal) (Notary Public Signature)

Tennessee Board of Dispensing Opticians
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, Tennessee 37243
Local (615) 532-5157
Toll Free (800) 778-4123

CLEARANCE FROM OTHER STATE DISPENSING OPTICIAN LICENSING BOARDS

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license to practice as a Dispensing Optician. If you were licensed based on the completion of an apprenticeship program, have the licensing state provide proof of completion of the apprenticeship program as well.

NOTE: Some states require a fee for providing clearance information. In order to expedite your application, you may wish to contact the applicable state or states.

****

I was granted _____ on _____ by the State of _____
Lic. # Date

The Tennessee Board of Dispensing Opticians requests that I submit evidence that my License in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Dispensing Opticians.

Date: _____ Signature: _____

SSN#: _____ Printed Name: _____

****

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD

License Number: _____ Date Issued: _____

Basis of Issuance: Endorsement/Reciprocity With: _____
Written Examination _____
(Provide Description of Exam)

License currently registered: _____ Yes _____ No

Derogatory Information on File _____ Yes _____ No
If "yes", please attach explanation.

_____ _____ _____
Authorized Signature Title Date

JK/G5097191/DPO

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243
www.tennesseeanytime.com

TENNESSEE BOARD OF DISPENSING OPTICIANS
State Exam on Statutes and Rules

Applicant Name: _____ Social Security No: _____

Date: _____

1) TRUE OR FALSE

Dispensing Opticians may not perform ocular refractions.

2) TRUE OR FALSE

Wholesale suppliers must be licensed dispensing opticians.

3) TRUE OR FALSE

Either a two (2) year opticianry degree or two (2) years of apprenticeship will satisfy the education/experience requirement for licensure.

4) TRUE OR FALSE

Licenses must be kept current, but need not be displayed at the practice location.

5) TRUE OR FALSE

An apprentice must have his/her finished work inspected by a licensed dispensing optician.

6) TRUE OR FALSE

An advertised price must be available for at least seven (7) days.

7) TRUE OR FALSE

Failure to timely renew one's license will result in administrative revocation of the license.

8) TRUE OR FALSE

Splitting or dividing fees with any person bringing or referring a customer is permissible.

9) TRUE OR FALSE

A license to practice is not necessary when working for a physician or an optometrist.

10) TRUE OR FALSE

All licensed dispensing opticians may fit contact lenses, regardless of the practice setting.

11) TRUE OR FALSE

The profession of dispensing optician is considered in Tennessee to be one of the healing arts.

12) TRUE OR FALSE

The optometrist instructs the patient on the use and care of the contact lenses, and the optician instructs the patient on insertion and removal.

13) TRUE OR FALSE

An optical dispensary must have a licensed Dispensing Optician on duty at all times.

14) TRUE OR FALSE

Retired licensees must pay a reduced renewal fee.

15) TRUE OR FALSE

To retire one's license, an affidavit of retirement need not be completed.

16) TRUE OR FALSE

Once a license is retired, that person may not practice Opticianry anywhere in the United States.

17) TRUE OR FALSE

Continuing Education must be maintained during the retirement period if reinstatement is desired.

18) TRUE OR FALSE

A licensee who has been revoked, suspended, or retired for a period of three (3) or more years must show current ABO/CLE certification and pass the state practical examination in order to reinstate.

19) TRUE OR FALSE

The total continuing education credit to be earned in any single 24 hour period cannot exceed eight (8) hours.

20) TRUE OR FALSE

Continuing education hours obtained as a requirement for reactivating a license may not be counted toward the calendar year requirement.

21) TRUE OR FALSE

Continuing education is always due on a calendar year basis.

22) TRUE OR FALSE

A licensed dispensing optician may not supervise more than three (3) apprentices at the same time.

23) TRUE OR FALSE

If a license is lost, it can never be replaced.

24) TRUE OR FALSE

Change of mailing address must be submitted in writing.

25) TRUE OR FALSE

Upon request of a client, the licensee must release a copy or summary of his/her records.

Revised 04/06
DPO-rules

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY

PRACTITIONER

PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health**.**

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider</u> to:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records.</u>**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(_____)_____**(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License #**_____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License#**_____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date:_____
(Signature of Provider)

YB/G6019027/RTK-ms.70